LOOE URBAN DISTRICT

COUNCIL

A N N U A L R E P O R T

OF THE

M E D I C A L O F F I C E R OF

H E A L T H

FOR THE YEAR 1950

P.J. Fox,
M.B., Ch.B., B.A.O., D.P.H.

LOOE URBAN DISTRICT

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH FOR THE YEAR, 1950

To the Chairman & Members of the Looe Urban District Council

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1950. As you are aware I hold a dual appointment, so that in addition to being Medical Officer of Health to six District Councils in south-east Cornwall I am also an Assistant County Medical Officer. In the latter capacity I represent the County Medical Officer, and am responsible for the day to day administration of certain sections of the National Health Service Act, 1946. Although District Councils have no statutory responsibility in the provision of health services under these sections of the Act, the fact that through the County precept on their rates, they contribute to the cost of these services, will make them interested in the nature of the service provided. I shall therefore refer to some of these services, which in my view merit comment, and which I believe are not fully understood by members and officials of District Councils.

Dealing with health matters in all six County Districts in Health Area No VII of the County I not un-naturally view these matters more frequently against the background of conditions in the Health Area as a whole rather than against that of the individual County District. Since social, economic, climatic and other conditions bearing on the health of the community do not vary substantially from one County District to another in Health Area No. VII, it is not surprising to find that conclusions drawn from the Area as a whole are valid for individual County Districts in that area. For this reason, and because my work as an Assistant County Medical Officer is carried out on an Area basis, I propose to make the preface to each of my six Annual Reports a general preface, and to deal in the body of the report with local variations from the state of affairs which obtains in the Health Area as a whole.

Health Area No VII of Cornwall County embraces the Municipal Boroughs of Liskeard and Saltash, the Urban Districts of Looe and Torpoint, and the Rural Districts of Liskeard and St. Germans. Its total area is 164,000 acres and the total population is just over 50,000. Some 60% of the total population lives in the two Rural Districts, the remaining 40% being in the four small urban areas which make up the Health area. There is no appreciable heavy industry in the Area, the emphasis being on agriculture. During the summer months there is a heavy influx of holiday makers to the coast which bounds the Area on the south, the chief centre of this activity being Looe. Though in theory such an influx may carry with it the risk of importing infectious disease into the Area, in practise this does not often happen. During 1950 there was some concern lest poliomyelitis, which was prevalent in many parts of the country, particularly in the midlands, might be brought to Cornwall by visitors. In fact three visitors from the Birmingham district developed the disease soon after arrival in Cornwall but in spite of the fact that the resort at which they were staying was extremely crowded, there was no extension of the disease to other visitors or the local population.

In referring to the state of health of the community in Area VII in general terms it is I think correct to say that on the whole it is up to the average of the country as a whole. Cornwall is a favourite place of retirement for those whose working days are over, and in consequence the population here contains a higher proportion of older people than the country as a whole.

Knowing this, it is reasonable to expect that the death rate in Cornwall would be higher than the country as a whole and that is what our statistics reveal. The fact that the average age at death is above that of the Country as a whole shows that the higher death rate is in this case no indictment of the state of health of the community. The birth rate is below the national average for similar reasons beyond our control. The absence of industry, with the attendant lack of employment for young people, means that numbers of people in the younger age groups leave Cornwall to work and live, and raise their families elsewhere.

Of the preventible diseases the most serious without a doubt is tuberculosis. Apart from the loss of life which it causes, the chronic invalidism which accompanies it represents a serious economic loss to the Community. The period of inability to work and earn a living is measured in tuberculosis, not in days or weeks but more often in months and years. It most frequently affects persons in early adult life, thereby invaliding them at what is normally their most active and productive phase of life. Moreover because of its communicable nature its victims inevitably suffer some social ostracism, though the position here has improved somewhat, and tuberculosis no longer carries with it the social stigma it did some years ago. It would not be unreasonable to expect that heroic measures would be called for, and would be justified in dealing with such a disease. Admittedly such measures would be expensive to put into operation, at least at the outset, but properly applied they would soon have shown returns not only in reducing human suffering, but also in lessening the size of the economic burden that tuberculosis places on the community. In fact tuberculosis has been, and is still regarded with too much complacency, and with an outlook that breathes too much of despair. The prompt removal of the tuberculous patient, and his retention in a place of isolation- the sanatorium- is still in too many cases a counsel of perfection, and so the patient remains at home, and often spreads the infection to another member of the household. We are all aware of the long waiting lists for admission to sanatoria, since from time to time articles and correspondence in the press give the matter some prominence. I do not wish to minimise the difficulties which beset those who wish and who endeavour to improve the facilities for the treatment of tuberculosis. The prime difficulty is that of providing sufficient nurses to adequately staff even the number of beds at present available, and the difficulty is correspondingly greater if regard is given to the number of beds which would be required to fully satisfy the needs of tuberculosis. I do not believe that the inadequacy of sanatorium accommodation is any worse in Cornwall than in the country as a whole, but there is no doubt of its existence. Of the 53 cases of pulmonary tuberculosis notified during 1950 in Health Area VII only 7 gained admission to Tehidy Sanatorium during that year, i.e. one person in every seven suffering from tuberculosis can hope to be admitted to a sanatorium in the early stages of the disease. In spite of the difficulties associated with the provision and staffing of sanatoria, and chest clinics, I feel that a bigger proportion of the expenditure on the National Health Service should be devoted to the prevention and treatment of this chronic, crippling disease. I feel that if some of the money which has been spent on the over-lavish provision of other less essential items in the National Health Service had been diverted to the prevention and treatment of really serious disease we should be on the right road to eradicating such scourges as tuberculosis from our midst.

Viewed statistically there has been little or no change in the incidence of or mortality from tuberculosis in Health Area No VII over the past three years, and the figures are on a par with those for the County as a whole. These statistics are given as an appendix to this report. Towards the end of 1950 a start was made on the B.C.G. vaccination scheme. This vaccine which has been extensively used on the Continent, especially in Scandinavia, has been found to stimulate in the body some resistance to tuberculosis infection. At present its use is confined to those persons who are exposed to a definite risk of contracting the disease e.g. close contacts of a case, nurses, and who have not developed any resistance to the disease. The necessity for removing suitable candidates for B.C.G. vaccination from any risk of infection for six weeks before vaccination, and six weeks after vaccination is a serious obstacle, and one which makes even more necessary the early removal to a sanatorium of cases, particularly where there are susceptible young adults and children in the household. I cannot leave the subject of tuberculosis without a reference to the importance of adequate housing in relation to this disease. One of the most important services a District Council can render to a family in which there is tuberculosis, is the provision of satisfactory housing, with adequate space, so that if at all possible the sufferer should have a separate bedroom. This measure of prevention is within the control of the District Council, when they are powerless to influence the provision of hospital accommodation, and I would therefore commend to all District Councils the claim of the tuberculosis patient on housing.

Another matter which has caused concern during the year is the inadequate provision for the care of chronic sickness occurring amongst aged and infirm persons. At the only hospital in this Area dealing with this type of case, there is invariably a long waiting list for admission. I do not wish to be critical of this state of affairs, but I feel bound to express my concern. Again much of the difficulty arises from shortage of staff - both nursing and domestic. It must be admitted that the care of aged, chronically ill people is not a very attractive career. It does not call so much for technical skill, as for a sense of devotion to the service of those unfortunate fellow-creatures, who through the burden of years, and infirmity are unable to care for themselves. Endeavours have been made to meet the need, by providing a shorter and less technical course of training for Assistant Nurses who would form the bulk of the nursing staff in hospitals for aged and chronic sick. As far as I can gather the response from suitable young women and men has not so far been very encouraging and it would appear that this difficulty is one which will not easily be overcome. Again I feel that the care of chronic and aged sick might have received more, and better consideration in the National Health Service, particularly as the proportion of older people in the community is on the increase, and there appears to be a tendency for relatives to leave their old folks to the Welfare State to be taken care of. There is some provision in the National Assistance Act whereby old and infirm persons who are adjudged by a court of summary jurisdiction as being incapable of caring for themselves can be removed to an institution or hospital on the order of the court. This piece of legislation, which is a direct interference with the liberty of the subject, is one which I personally have not been called upon to certify as necessary in any case, though in at least two cases it has been given serious consideration.

The fact that seven days notice of the making of this application must be given to the court and to the persons managing the premises to which it is intended that the aged or infirm person should be removed, makes this the use of this section unsuitable for dealing with urgent cases.

One of the greatest triumphs of preventive medicine has been the virtual eradication of diphtheria from the community as a result of the successful immunisation campaign which has been in progress throughout the country over the past 10 years. The success of this campaign can be measured by the reduction in the number of cases notified. This in 1940, in the County of Cornwall 392 cases of diphtheria were notified, while in 1949 the figure had fallen to 3 - a truly wonderful result. During the years 1948-1950 inclusive, in the whole of Health Area No. VII one case only of this disease has been notified to me. It would be a thousand pities if the valuable gains of the last decade in this sphere of public health were to be lost through apathy or groundless fears of the alleged ill-effects of immunisation on that other scourge of childhood-poliomyelitis. The absence of a disease from the community tends to breed in that community a sense of apathy towards the potential dangers and consequences of that disease. It is understandable that most young parents whose memories of the disease as it existed in their childhood have grown dim, and who know nothing of it in relation to their own or their neighbours children, should sometimes fail to realise the seriousness of the position which will arise if large numbers of the rising generation of children are not protected by immunisation. Unfortunately certain conjectures on the possible effect of recent diphtheria immunisation on the incidence, and severity of paralytic poliomyelitis found their way into the popular press during 1950, and created in the minds of parents a certain amount of opposition to diphtheria immunisation. There has been no clear proof that such adverse effect does in fact follow diphtheria immunisation, and in at least one recent report no such association could be found. Diphtheria has not wholly vanished from the country, and given suitable soil - a child population with an increasing number of non-immunes- it will soon re-establish itself, and will again become one of the grim reapers of young lives.

Another disease which effects children and adolescents is poliomyelitis. This disease is perhaps better known as infantile paralysis, though in fact it can attack adults, and it does not always cause paralysis. The virus which causes it has become much more widespread in recent years in the British Isles and outbreaks of this disease have appeared without fail each summer and autumn in sufficient numbers to attract attention since 1947. The mode of infection and subsequent spread of the disease is difficult to trace, and it is common to meet isolated cases where there is no obvious source of infection, and the disease does not spread any further. Infection is probably spread by droplets from the nose, mouth and throat and probably also from the bowel. Because of its morbid "news value" the disease has received a good deal of publicity in national and local newspapers, and the general public, especially the parents of young children have become very "polio" conscious. Unfortunately this gives rise to a good deal of unreasonable anxiety, amounting in some cases to panic, and the occurrence of a case of poliomyelitis is almost always accompanied by rumour and speculation which bear little relation to the true state of affairs. There is great need to take a balanced and reasonable view of this disease, so that parents may be spared undue distress and worry.

Although the disease is notorious for the paralysis it can and does cause, about 25%-30% of the cases notified in 1950 throughout the country did not suffer from paralysis. Again during 1947 when poliomyelitis was present in this country in epidemic form, there were 688 deaths from the disease, whereas tuberculosis caused 23,075 deaths and 4071 persons were killed in traffic accidents. Thus whilst poliomyelitis is a serious disease, it is important that we keep it in its proper perspective in relation to other hazards to life, and limb. As far as Health Area No. VII was concerned the incidence of poliomyelitis during 1950 was considerably above that for the two previous years. In all 14 cases were notified of which 10 were accompanied by paralysis, while in 4 there was no paralysis. There were no deaths from this disease. The case rate per 1000 of the population was 0.27 as against a rate of 0.18 for England and Wales as a whole.

Of the other infectious diseases notified during 1950 whooping cough and pneumonia were most numerous. With pneumonia, erysipelas and meningitis the local case rates were above the national figure, whilst with measles, whooping cough, scarlet fever and puerperal pyrexia the local case rates were better than those for England & Wales.

In my report for 1949 I referred to the supremely important part played by housing in the national economy. The demand for new houses continues unabated, and everywhere the claims of eager applicants outnumber the new dwellings which can be made available. The only factor which puts any curb on the apparently insatiable demand for new houses, is the relatively high rent which now attaches to new houses. This is the inevitable result of increased costs of wages and materials operating in the building industry. As far as housing is concerned it is interesting to observe that the fulfilment of the manual workers demand for higher renumeration, and increased leisure has reflected back so adversely on themselves and their families when they require to be rehoused. Many relatively well-paid manual workers are now finding it difficult to meet the high rents which are due in part to the higher wages paid to their colleagues, in the building industry. As far as social welfare, and public health are concerned it is most unfortunate that these factors should operate against the rehousing of those who require it, but it is not a matter which can be easily remedied. National and local financial resources are strained to well nigh breaking point, and the provision of further subsidies for housing, food or indeed any other public service is almost out of the question. Nothing short of increased productivity, and the best possible use of scarce and expensive materials holds out any hope for rehousing those who most require it at a cost they can afford to pay. It is hardly necessary to remind you that the provision of good housing is dependent on the availability of ancillary services, with water supply to the forefront. The progress of housing schemes is made much more difficult by the absence of these services, a fact which many of the less progressive rural areas throughout the country are now discovering in the very hard, and very expensive post-war school of experience. Considering all the difficulties which surround the problem of providing an adequate number of new houses togetherwith the requisite ancillary services, I consider that District Councils in this Area have all made very good efforts in this direction

Water supplies in the Area are variable, ranging from piped supplies of pure water to indifferent and dangerously polluted supplies from shallow wells and springs.

In all cases there is anxiety during the dry summer months concerning the quantity of water available, and with piped supplies restrictions on consumption are usually necessary. In the case of the smaller schemes in villages and hamlets there is sometimes complete failure of the supply and expensive and inadequate substitutes have to be provided. The Liskeard Rural District Council and the Liskeard Borough Council have embarked upon a joint scheme of considerable magnitude, which has as its object the provision of a pure supply of piped water to the whole of the Liskeard Rural District, at present badly served in this respect. As with all undertakings of this description the progress of the work is frustrated and impeded by shortage of materials, and the ever present bogey of rising costs. It is also worth remembering that the demands of the defence programme and such measures as the National Health Service or the national income are so heavy, and pressing that the Governments grants to aid local schemes and projects of water supply and sewerage may be much less generous than had been anticipated. This will lay a correspondingly heavier burden on local finances, and it may well be found that comprehensive schemes of water supply and sewerage though necessary, and long overdue cannot be undertaken through lack of ability to meet the high cost of such schemes.

The standard of sewerage and sewage disposal is generally unsatisfactory throughout this Area. In only one of the larger urban communities is any attempt made to treat sewage before discharging it to a waterway, and even here the plant used is obsolescent and unsatisfactory. In villages and hamlets in the rural parts of the Area arrangements for sewerage and sewage disposal are generally primitive, inadequate and unsatisfactory. It is true that where new houses are constructed efforts are made to improve the state of affairs, and provided such small sewage disposal plants are carefully and regularly maintained they are tolerably efficient. As with water supply schemes the planning & provision of larger sewerage schemes is delayed and discouraged by a multitude of difficulties, the greatest of which is the high cost of such schemes. No one is prepared to argue against the necessity for the provision of water and sewage disposal- indeed the modern citizen and ratepayer regards these services less and less as amenities and more and more as the bare and basic necessities of life, especially if he has come from districts where they have been provided. Whilst as an official primarily concerned with the prevention of disease and the promotion of health I must advise and even urge the provision of these services, nevertheless I must temper my enthusiasm with a sense of reality. Unfortunately the harsh and easily perceptible reality of the matter is our physical and financial inability to provide these services. In thinly populated rural areas the over-riding difficulty is one of finance, though shortage of labour, and materials and transport difficulties all contribute to the slow progress in solving these problems. During and since the war many city and town dwellers have come to rural areas to live. They have in most cases been appalled by the primitive conditions existing in many rural areas and some have been vociferous in their demands for these things which are the normal concomitants of life in a large community. Whilst we must never abate our efforts to improve living conditions in rural areas, we must recognise the formidable financial and physical obstacles which conf ont our endeavours in this direction, and we must never lose sight of the magnitude of these problems.

It is not perhaps generally understood that the social services, of which the public health service is one, are in effect purchasable commodities, and have to be paid for out of a fixed and limited national income. However much a private individual may wish to spend on the promotion and preservation of his health, the size of his income inevitably places some limit to the amount he may devote to this purpose. This is equally true in the national life, and limits the size and scope of any service, to that which the community can pay for. Health Many people seem to regard the scope and benefits of the National/ Service as limitless, and do in fact use the Service as though that were the case. That such is not the case , successive Chancellors of the Exchequer have made abundantly clear, and they have in fact endeavoured to fix a "ceiling" beyond which the cost of the National Health Service may not rise. This necessary restriction on the size of the national bill for health services, means that within the National Health Service the various interests which provide health schemes and services have to compete with one another for a share of the limited total available. In such competition there is danger that the popular clamour for one type of service may ensure for it a larger share of the available funds than its real merit may give it title to, whereas the claims of less obviously beneficial parts of the service may suffer. Personally I should need a lot of convincing, that the satisfying of the gargantuan thirst of the British public for liquid medicine is more important than the eradication of tuberculosis, or that the wholesale provision of dentures is more valuable than the care of those to whom age or chronic illness has brought infirmity. Most thinking people will agree that the logical way to approach the question of health in the nation is to adopt the positive approach - to teach people to acquire and promote good health in themselves and their families, and to keep disease at bay by preventing it. Yet in the present National Health Service the main emphasis is on curing disease, with preventive services a very poor second, being allocated only 8% of the 450 million pounds which the National Health service claims from the national income. However wrong this outlook may be it will be very hard to alter it, and I see little prospect of a more logical approach to this question of health being adopted for many years ahead. Nevertheless it is something for which we must all strive, in our endeavour to make the best possible use of our limited national resources.

In the foregoing preface which will be common to the six Annual Reports I am called upon to write, I have touched upon those aspects of public health, and social medicine which seems to me to be important and to merit comment. Most of what I have had to say is not original, and has been more convincingly and skillfully put by my colleagues in other parts of the country. The opinions and judgments I have formed are therefore not altogether my own, though their application to the area in which I work, and live is my responsibility. Some who read this Report will not agree with the conclusions I have reached and the opinions I have formed. I can only hope that in stimulating them to disagree with me, I may alsostimulate them to seek after the best means of attaining our common goal - the good health and happiness of the community. We must all contribute in greater or lesser measure to the modifying and moulding of our social services so that they yield the best results. The National health service is one of the most recent arrivals on the scene, and it is without doubt one of the greatest experiments in social welfare so far undertaken in the world.

To really succeed it will require all the support, encouragement and guidance that thinking people everywhere can give.

I cannot conclude without thanking all who have assisted and encouraged me during the year 1950 in my endeavours to improve the health of the public in this part of Cornwall. May I hope that this co-operation will be extended to me as long as I continue to serve in this Area.

I have the honour to be

Mr. Chairman, Ladies & Gentlemen,

Your obedient Servant

P.J. FOX

Medical Officer of Health

LOOE URBAN DISTRICT

Area of Urban District	1649.5 acres
Population (Registrar Generals Estimate)	3714
Number of Inhabited Houses	1229
Sum represented by Penny Rate	£158
Rateable Value	£38,966

Vital Statistics for 1950

Live Births	Male	Female	Total
	17	25	42

	Looe U.D.	Health Area 7	England & Wales
Birth rate per 1000 of population	12.3	15.1	15.8

Still Births	Male	Female	Total
	-	2	2

	Looe U.D.	Health Area 7	England & Wales
Stillbirth rate per 1000 of population	0.54	0.32	0.37

Deaths	Male	Female	Total
	21	24	45

	Looe U.D.	Health Area 7	England & Wales
Death rate per 1000 of population	9.2	13.7	11.6

Deaths attributed to Pregnancy, Childbirth and Puerperal State
No deaths were registered under these heads

Deaths of infants under One Year of Age
No deaths were registered under this head

Deaths from Enteritis and Diarrhoea Under Two Years of Age
No deaths were registered under this head

Principal Cause of Death at All Ages

Heart Disease	27
Cancer (all sites)	7
Genito-urinary disease	5
Respiratory disease	1
Accidents	1

Average Age at Death

Males	Females
72.45	72.56

Once again Looe Urban District shows a low birth rate as compared with the surrounding area, and the country as a whole. I previously suggested that this is probably due to the large percentage of older people in the local population. The death rate is the lowest in south east Cornwall, and is well below the national figure. Moreover the average age of death is the highest in south-east Cornwall, and the difference between males and females is considerably less than is generally experienced i.e. during 1950 the expectation of life for males in Looe was virtually that of females instead of being about three years less. As far as the causes of death are concerned, heart disease accounted for a higher proportion of the total deaths than is usually found, whilst it is surprising that "stroke" which normally lies second or third in the list of principal causes of death was not responsible for a single death in Looe. It is pleasant to put on record that no maternal or infant deaths occurred during 1950 in Looe.

Infectious Disease - During 1950 a total of 32 cases of notifiable infectious disease (excluding tuberculosis) occurred in the Urban District. This compares with 87 cases in 1949, and 27 cases in 1948. The most prevalent disease was whooping cough, of which 13 cases occurred. In the early summer of 1950 there was a heavy incidence of poliomyelitis in some large cities in the Midlands. It was therefore with some trepidation that I awaited the peak of the holiday influx of visitors into Looe since I expected that numbers of people from the infected areas in the Midlands would almost certainly find their way to Looe. We did in fact have three cases in visitors to Looe at the height of the tourist season, but there was no spread of the disease to other visitors or to the local population. This is very surprising in view of the congestion and crowding of the town which takes place during July and August. Surprisingly enough in early November, when the visitors had long departed, and the town had returned to its normal off-season quiet, a further case in a resident of Looe occurred. No other case occurred in association with this one, and there was no clear indication of the source of infection.

The following are details of actual numbers and cases of infectious disease occurring in Looe during 1950.

Disease	Cases Notified	Case rate per 1,000 of Population		
		Looe U.D.	Health Area 7	England & Wales
Whooping Cough	13	3.50	3.13	3.60
Measles	5	1.35	0.44	8.39
Scarlet Fever	5	1.35	0.84	1.50
Pneumonia	4	1.08	1.26	0.70
Paralytis Polio-myelitis	3	0.81	0.19	0.13
Non-Paralytic Poliomyelitis	1	0.27	0.08	0.05
Erysipelas	1	0.27	0.36	0.17

Tuberculosis

During 1950 the number of new cases of tuberculosis notified in Looe was 4. This shows a further small reduction on the totals of 5 cases in 1949 and 7 cases in 1948.

There were no deaths from tuberculosis during the year and at the end of 1950 there were 22 known cases of tuberculosis resident in Looe, of whom 20 suffer from pulmonary tuberculosis and 2 from non-pulmonary tuberculosis.

The following are details of new cases and case rates during 1950:-

Age Group	New Cases		Deaths
	M	F	
0 - 1	-	-	
1 - 5	-	-	No deaths from
5 - 15	-	-	
15 - 45	1	2	tuberculosis in
45 - 65	1	-	
65 & Over	-	-	1950

Rates per 1000 of Population

	Looe U.D.	Health Area No. 7
New Cases	1.08	1.01
All cases	5.92	5.12

The first of these tables shows that tuberculosis attacked wholly in the adult age groups i.e. between the ages of 15 and 65. This is the normal state of affairs in tuberculosis infection, which disables people during the most productive and active period of their life.

National Assistance Act, 1948. - No action under Section 47 of this Act was called for during 1950.

Water Supply

Although the resources of the South East Cornwall Water Board were strained to the utmost, the Urban District had at all times an adequate supply of water. The quality of the water was at all times beyond reproach.

Sewerage and Sewage Disposal

Sewage is still discharged untreated to the tidal estuary of the river which passes through the centre of the town. This is of course an unsatisfactory state of affairs, but in view of the engineering difficulties and the high cost of an effective scheme it is unlikely that any improvement will take place in the near future.

Food. Routine inspections of premises dealing with and serving food were undertaken during the year. In this matter particularly as it affects hotels and cafes where food is cooked and served Looe ranks as one of the most important places in south-east Cornwall. During the height of the summer season the number of meals cooked and served must run into hundreds of thousands and the risk of an outbreak of food poisoning affecting appreciable numbers is correspondingly great. Fortunately no such outbreaks have so far occurred, but the possibility must never be lost sight of. The task of inspecting all the hotels, cafes and boarding houses in Looe is a formidable one, particularly as Mr. Hicks, the Sanitary Inspector is also Surveyor and can therefore devote a relatively small part of his time to this matter, Nevertheless it is hoped that all such places will eventually be visited and where necessary the proprietors will be advised on correct methods of handling food.

In other respects Looe is an important centre in relation to food. There are four ice cream factories in the Urban District, which in addition to providing large quantities of ice cream to the summer visitors to Looe also distribute their products widely over the surrounding district. It is therefore important that regular supervision of these factories, combined with regular sampling of their products should be undertaken, and this was in fact done during 1950. Although these factories are modern in design and equipment, the number of lower grade samples produced gave cause for some anxiety. As Mr. Hicks notes in his Report, assistance was offered by a firm interested in the production of clean ice-cream, and their offer was accepted. As a result of a two day visit by one of their technicians, certain minor departures from the correct routine of sterilising plant were noted, and appropriate advise was given. It is believed that this will considerably improve the standard of products in the future. Whilst on this subject it is only fair to report that all the ice cream manufacturers in Looe produced an article of high food value, as judged by the fat content, throughout the year.

Food Poisoning. As reportedin the previous paragraph no cases of food poisoning occurred during 1950.

Clean Food Campaign No such campaign was conducted during 1950. 1950.

Housing. Steady progress in building new houses was maintained during 1950 when 20 houses were completed and occupied. In addition 6 houses built by private enterprise were completed and occupied. There is still a considerable demand for rehousing.

Factories Act, 1937. No difficulties in administering the provisions of this Act were experienced during 1950.

Report of the Sanitary Inspector.

The report of the Sanitary Inspector, Mr. J.C. Hicks, C.R.S.I. which follows gives an outline of the work carried out by Mr. Hicks in his capacity as Sanitary Inspector. In spite of having to carry out single handed the multiplicity of duties associated with the dual appointment of Surveyor and Sanitary Inspector, I have at all times found Mr. Hicks most co-operative and helpful, and I should like to take this opportunity of thanking him for all the assistance he has given me during 1950.

Report of Sanitary Inspector

Factories, Workshops and Bakehouses

These were periodically inspected

1. Inspections for purposes of provision as to health (including inspections made by Sanitary Inspectors) Factories Act, 1937

	No. on Register	Inspections
(i) Factories in which sections 1,2, 3,4 & 6 are to be enforced by Local Authorities	10	39
(ii) Factories not included in (i) to which section 7 applies	-	-
(iii) Others	3	4
	13	43

2. Cases in which defects were found

Particulars	Defects Found	Defects Remedied	Referred to H.M. Inspector
Want of Cleanliness (S.1)	-	-	-
Ineffective Drainage of Floors (S.6.)	-	-	-
Sanitary Conveniences	1	1	-
Other	1	1	-
	2	2	-

Ice Cream

There are now four Ice Cream Factories with modern equipment in the Looe Urban District.

During 1950 57 samples of Ice-Cream were taken for evidence of Bacterial contamination and for grading, and 24 of these were analysed for fat content.

The results were:-

13 at Grade 1
15 at Grade 2
14 at Grade 3
15 at Grade 4

Owing to the number of samples falling below grades 1 and 2, contact was made with the Deosan Co. Ltd, who sent their representative, Miss Z. Fowler, B.Sc. on the 4th and 5th of October.

Miss Fowler spent the whole of these two days in the factories, taking tests and advising, this was greatly appreciated by the factory owners.

It is hoped that it will have the desired effect the raising the standard of the grades during the next season. The fat content in the samples analysed was well above the required standard

Food Canning

During the year the following pilchards were dealt with:-

14 oz Oval Cans	1,428,831
A.I. Tall Cans	34,891

Sprats etc.

½ Dingley Cans	11,257

Processed Peas

No 1 Tall Cans	352,748

Water

During 1950, the quality and quantity of the water supplied was satisfactory, all water being supplied by the South East Cornwall Water Board, and is piped throughout the area.

The number of houses is 1229 and the water is carried to 1219.

Meat and Other Foods

Because of the Central Slaughtering System, which is being carried out at Liskeard, the slaughterhouses in this district are not in use. However, meat and other foods are inspected when the occasion arises

Drainage and Sewerage

No progress has been made with the sewer at East Cliff owing to the fact that Private Enterprise Building is still restricted.

Refuse Collection and Disposal

Collection of house refuse is carried out twice weekly during the holiday season, and once during the winter.

Refuse is collected from 1470 premises, and disposal is by Incinerator.

Previous to July, 1950, the collection of the refuse was carried out by contract. In July the new refuse collection vehicle was delivered and the whole of the work is now undertaken by the Council.

Inspections of Dwelling Houses during the year

Total number of dwelling houses inspected for defects under Public Health Act and Housing Acts.	56
Other inspections such as drainage defects, etc.	27
	83

Your obedient Servant

J.C. HICKS

Surveyor & Sanitary Inspector.

APPENDIX 1

Incidence of and Mortality from Tuberculosis in Health Area No. 7 - 1950

Age Group	New Cases		Deaths	
	Male	Female	Male	Female
0 - 1	-	-	-	-
1 - 5	2	-	-	-
5 -15	5	2	-	-
15 -45	13	18	7	4
45 -65	6	2	4	2
65 & over	3	2	3	1
Totals	29	24	14	7

	Male	Female
Case rate per 1000 of population	0.55	0.46
Mortality rate per 1000 of population	0.27	0.13

Case Rates and Mortality Rates per 1000 of Population by Sanitary District in Health Area No. V11 - 1950

	New Cases	Total Cases as at 31.12.50	Deaths
Liskeard M.B.	2.30	5.99	0.46
Liskeard R.D.	0.49	3.52	0.42
Looe U.D.	1.08	5.92	-
St. Germans R.D.	1.07	6.50	0.44
Saltash M.B.	0.92	5.68	0.66
Torpoint U.D.	1.15	3.45	0.14
Health Area No. V11 Cornwall	1.01	5.12	0.40
England & Wales	Not Known	Not Known	0.36